Reframing Care Practices on Transgender Health: The International Campaign Stop Trans Pathologization

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Abstract

Transsexuality has been organized within the biomedical framework since the middle of the twentieth century. The gendered body is produced through a complete set of socio-medical practices in order to regulate the human variation on gender expressions. In this binary model, there are only two sexes and two possible gender positions. People who do not fit in this very normative model have to change the body to adjust it to the normative idea of how a male or a female body should be. However, at the turn of the twenty-first century, several activist movements and certain feminist-queer academic traditions have questioned this version of sexual difference. In this article, I will analyze how a particular transgender activist group is questioning the production of both sexual difference and specific models of gender identity through medical practices on transgender bodies.

Introduction

Transsexuality has appeared as a 'mental disorder' in different versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (since the third version published in 1980), and in the current 10th version of the International Classification of Diseases (ICD), endorsed by the World Health Organization (WHO). Both texts serve as the worldwide reference on diagnostic manuals, at least in the western medical culture.

Sexual difference has been profusely analyzed from different disciplines and perspectives. In this paper I will focus on the production and emergence of sexual difference in a specific time and place, and within a particular biopolitical frame (Foucault 1976). Biomedicine is the framework through which bodies are regulated in order to fit in the sex/gender scheme within the age of scientific knowledge.

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Different conceptual models and normative frames in relation to sex, gender, and sexuality categories have been explained from the historiography of sex and sexuality, from the history of science, and from feminist and gender studies (Laqueur 1994; Schiebinger 1991; Schiebinger 1993; Vázquez García & Cleminson 2010, 2012). From these perspectives, it is stated that ideas about the sexes have changed throughout history, despite the fact that the 'two sexes model' has been predominant since the eighteenth century. This model naturalizes sexual difference, considering that it justifies all the perceived differences between the sexes as being biological.

Since the nineteenth century, medicine has been responsible for the normative regulation of the body as part of a broad biopolitical project of population control (Foucault 1963). Medicine plays a main role in the biopolitical regulation of the social order, identifying as pathological and as an object of medical intervention those bodies that do not fit in the norm. In this case, sexual difference is in the center; it is the origin of the transsexual category. In other words, transsexual is a concept that can only be understood if the meaning is linked to biomedicine. Therefore, it is very relevant to investigate the forms in which medicine has regulated transsexuality's space.

Medical science, activist movements, and the Spanish gender identity law

There has been a movement to classify 'deviant' sexual behaviors in the medical literature since the last decades of the nineteenth century. In this context, the term transsexual appeared for first time in medical literature in the work of David O. Cauldwell (1949): '*Psychopathia Transexualis*'. Historically, there are other references in the works of the great nineteenth century sexologists: Kraft-Ebing, Havelock Ellis, and Magnus Hirschfeld—the most significant figure in transgender studies. However, none of them used the word transsexual in the same meaning that it is used at present (Ekins & King 2001; Hausman 1995; Hirschfeld 1910; King 1998; Meyerowitz 2002). Afterwards, during the decades of the 1950s and '60s, transsexualism as a 'syndrome' was introduced into other medical

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disciplines such as endocrinology, and became a familiar term to U.S. society through cases such as Christine Jorgensen's—a transsexual woman then known by the general public through the media (Meyerowitz 2002).

During the '60s and '70s, endocrine treatment and sex change surgeries for transsexual people were developed in the U.S. by very prestigious universities including Johns Hopkins and UCLA. From 1920 to 1960, sex change surgeries were occasional, and surgeons performed them under patient petition. There were neither protocols nor established diagnostic criteria for these (Stone 1992).

Harry Benjamin, an endocrinologist who participated in Christine Jorgensen's case, and who had treated a great number of transsexual people, made a compilation of clinical cases and medical interventions on bodies, published as *The Transsexual Phenomenon* in 1966. It established the basis for a systematized medical treatment of transsexuality, and came to be the main reference for different medical specialists. Some authors suggest it became a major reference for transsexual people as well, who found in it a guide to getting medical treatment (Billings & Urban 1998). During the period of development of medical technologies, between 1950 and 1970, Harry Benjamin was the main reference in defining both medical diagnosis and forms of intervention. But at the end of the '70s and the beginning of the '80s, a new set of artifacts used to define transsexuality emerged.

In 1979, the first version of the *Standards of Care* (SoC) was published by the Harry Benjamin International Gender Dysphoria Association (HBIGDA). The six following versions of the *Standards of Care*—the seventh version was published in July 2012—became the handbook for medical treatment of transsexuality that is followed by almost every doctor in the western culture until now. Shortly after, in 1980, the DSM-III introduced 'transsexuality' as a diagnostic category and a mental disorder for first time.[1] DSM-IV changed the name of the category to 'Gender Identity Disorder' in 1994 (American Psychiatric Association 1980, 2000).

The same kind of change in the nomenclature of the disorder is produced in the SoC according to different versions of DSM. Versions 1 to 6 of the SoC have several points in common. Versions 1–6 state that transsexuality is a mental disorder—according to DSM—that shouldn't be

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treated in the brain, or in the mind, but in the body. All of them maintain the triadic therapeutic sequence: first, psychotherapy and diagnosis based on DSM; second, hormonal treatment; third, sex reassignment surgery (WPATH 2012).

Diagnosis criteria defined by DSM and ICD, and the Standards of Care described by HBIGDA, will homogenize a model for identifying, treating, and caring for transsexual and transgender people. In fact, this model has become the criteria to acquire legal recognition of name and sex changes in some western countries. This is the case, for instance, with the Spanish Law 3/2007, which regulates the rectification of the national registry concerning a person's sex and name, and known as the 'law of gender identity'. It requires a diagnosis of 'gender dysphoria' as displayed in ICD or DSM, as well as two years of medical treatment (Ley 3/2007).

In the meantime, during the last four decades—since the '70s and '80s, but especially in the '90s and the first decade of the twenty-first century—some activist movements have been organizing the resistance against the medicalization of transsexuality, promoting other ways of identifying transgender situations and its socio-medical definition. Thus, the emergence of a feminist, queer, and transgender literature has been quite important in this redefinition of transgender issues, because it has allowed questioning, and it has contextualised normative gender models, as well as reclaimed non-normative gender positions, and identified political categories as 'transgender'. This category was articulated in opposition to the rigid medical model that describes the figure of 'transsexual'.

In the Spanish context, transsexual activists were integrated in the more general collectives for sexual rights in the '70s, such as *Movimiento Español de Liberación Homosexual* (MELH) (Spanish Movement for Homosexual Liberation) and *Front D'Alliberament Gai de Catalunya* (FAGC) (Catalonian Front of Gay Liberation). These collectives worked underground during Franco's dictatorship and tried to repeal the 'Social Danger and Rehabilitation' Act (1970). After the dictatorship, in the first years of democracy (since 1978), there has been a movement of openness towards sexual rights (Platero & Ortega-Arjonilla 2015). Old laws like the 'Social Danger and Rehabilitation' Act were repealed, and in 1983, the ban on sex reassignment surgeries was lifted.

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Afterwards, at the end of the '80s, the transsexual movement started to organize independently from lesbian and gay collectives. In 1987, the Spanish Transsexual Association (ATET-Transexualia)—the first activist group of transsexuals—was mainly created by transsexual women working as sex workers, and whom were pursued by the police very frequently (Platero 2011; Ramos Cantó 2003). Several transsexual associations were formed in the '90s, which had specific claims, and differentiated themselves from gay and lesbian organisations. This was the starting point in the struggle for legal recognition, and for social and health rights in Spain.

In the mid-2000s, the transgender section of the *Federación Estatal de Lesbianas, Gais, Transexuales y Bisexuales* (FELGTB) (National Federation of Lesbians, Gays, Transsexuals and Bisexuals Organizations) took the lead to negotiate all the issues related to transgender and transsexual rights with the national authorities, including the legal recognition of gender identity and health issues (Platero 2011). In a more open context for sexual rights in Spain—i.e. in 2005 same sex marriage was approved—the negotiation of the transsexual collectives' claims started, and finally, in 2007, what is known as the 'Gender Identity Law' was passed. But Law 3/2007, which regulates the rectification of the national registry concerning a person's name and sex, means at the same time a reinforcement of pathologizing positions that consider transsexuality as a mental disorder. Law 3/2007 regulates the rectification of the registry regarding a person's sex and name through a medical process in which a mental health professional certifies a 'gender dysphoria' diagnosis, and candidates have to undergo at least two years of medical treatment.

As R. Lucas Platero, a trans-feminist activist and researcher has accurately analyzed, a direct consequence of the approval of the Law 3/2007 is the impulse and the main role that radical collectives and associations have been playing from that moment on (Platero 2009, 2011). Since 2007, radical activist collectives claiming for the depathologization of trans identities—including *Guerrilla Travolaka* and *ATC-Plataforma sin vergüenza* in Barcelona, and *La acera del frente* in Madrid—have occupied a main role. Furthermore, they have placed themselves as main actors in the controversy about the frameworks in which gender identity is built, and have displaced FELGTB from the centre of the discourse about trans issues.

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'International Campaign STP' and the rise of lay expertise

Since 2007, and with growing support especially from 2009, we have seen the appearance and rise of the Spanish Network for Trans Depathologization, later the International Network for Trans Depathologization, International Campaign Stop Trans Pathologization 2012, and finally International Campaign Stop Trans Pathologization. All these changes in the name reflect a network which has been mutating, moving beyond national context, increasing support, and gaining ability to influence.

In the beginning, it was a network created at a national level to coordinate all these previous radical activist transgender collectives and other feminist and queer collectives fighting against the law 3/2007, and the medicalization of trans identities and other non-normative gender positions. Now, the influence of the International Campaign STP can be seen in different social and medical spaces in the brand new version of Standards of Care-7, the public debate of DSM-5, and in debates around the new version of ICD-11, among others. Even though the STP Campaign is not the only new actor in this controversy, I want to show the role of the Campaign considering that it displaces and reorganizes the debate, and that it rearticulates the spaces of knowledge production.

From the moment the campaign became international, it has marked five main objectives in its demands:

1. The removal of 'Gender Dysphoria' and 'Gender Identity Disorders' categories from the international diagnosis manuals (their next versions DSM-5 and ICD-11).
2. The abolition of binary normalization treatments to intersex people.
3. Free access to hormonal treatments and surgery (without psychiatric monitoring).
4. Public coverage of trans-specific healthcare (optional therapeutic counseling, gynecological/urological monitoring, hormone treatments, and surgeries).

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5. The fight against transphobia: the work for educational training, and social inclusion and employment of trans people, as well as the visibility and reporting of all types of social or institutional transphobia (STP 2010).

These five international objectives are embodied in some 'situated practices' (Haraway 1988) in the Spanish context in which the objectives are turned into six concrete demands:

1. Removal of the requirements of diagnosis and medical treatment for the rectification of the national registry concerning a person's sex and name in the Law 3/2007.
2. Abolition of the ban regarding names that 'mislead about sex' in article 54 of the Civil Registry Law.
3. Removal of the reference about sex in official documents of public nature.
4. Inclusion of the 'gender reassignment process' in the health services of the National Health Care System.
5. Changes in the clinical practices regarding 'gender reassignment process': From a medical consent model to a self-autonomy-based model that recognizes the right of trans people to decide about their own body modification process.
6. Participation of the trans movement in the process of modifying the Law 3/2007, and in the production of the transgender health policies (Red por la Despatologización de las Identidades Trans del Estado Español 2010a).

Based on those demands, a displacement from a biomedical and biopolitical paradigm (Foucault 1976) to a Human Rights paradigm is required. This paradigm based on human rights related to the transsexual and transgender community are gathered in the Yogyakarta Principles (2007).

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Best practices guide to trans health care in the national healthcare system

In October 2010 (December in the English version) the Network published a document titled *Best Practices Guide to Trans Health Care in the National Health Care System* ('The Guide'). This is an alternative document to the Standards of Care, sixth version (Meyer III et al. 2001) that should be developed in the Spanish health care context, but at the same time, it was created as a document that might have some influence in the WPATH's commission in charge of the discussion and writing processes of SoC-7 (Coleman et al. 2012).

The Guide is a milestone regarding the implications of trans activism in transgender health issues. It settled a new position in some epistemological debates, like the relationship between experts and lay people in the construction of scientific knowledge (Callon & Rabeharisoa 2003, 2008; Epstein 1995, 1996, 2007), or how we should build the scientific knowledge in the STS ontological turn (Callon, Lascoumes & Barthe 2009; Callon & Rabeharisoa 2003; Mol 2002, 2008; Mol, Moser, & Pols 2010).

The Guide is an alternative to perspectives about trans issues made from the health field—mainly from DSM and SOC—even though the kind of discourse developed in The Guide and based on a Human Rights perspective has been settled from LGTB and queer research (Yogyakarta Principles 2007). Historically, the trans health field has been organised by medical professionals participating in trans health care: mental health professionals, endocrinologists, and surgeons. Within this framework trans health issues start with the diagnosis of a 'disorder', concretely a Gender Identity Disorder (GID), as it is categorized in DSM-IV (American Psychiatric Association 2000), and therefore the discourse has been a pathologizing one from the beginning. In the Guide, trans identities are recognized as part of human diversity. Transsexuality is not conceived as a mental disorder, or as an organic or physical condition, but like other physical processes of the body, such as pregnancy, that require medical care (Red por la Despatologización de las Identidades Trans del Estado Español 2010b, 16-17).

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After analyzing The Guide in contrast to SoC 6—the Standards of Care current at that time—I have found four important aspects to consider for a reconceptualization and reorganization of care processes for trans people:

a) Openness and scrutiny of the psychological and diagnostic processes;
b) Reconfiguration of the demand for intervention;
c) Demand of the logic of choice in order to find better care;
d) And finally, a 'blackboxing' of the hormonal treatments and surgical interventions.

Here, I am using the concept of 'blackboxing' in the sense of Actor Network Theory (ANT), to refer to technologies that remain unquestioned or naturalized (Latour 1987, 1999).

Openness and scrutiny of the psychological and diagnosis processes

The main objective of The Guide is dissociating transsexuality from the mental health and mental disorder frame. In this sense, the new approach proposed in the Guide will be centered in the reshaping of medical practices related to mental health professionals.

The theoretical position in The Guide referring to mental health professionals is taken from the proposal of the Spanish psychologist Cristina Garaizabal (2003, 2006). She defines accompaniment as the most important practice of mental health professionals regarding transsexual people, and she makes a commitment for the depathologization framework in which a new relationship should be established:

> The creation of an essential and necessary atmosphere of trust in any therapeutic relationship is almost impossible if the therapist is considered a judge who has in his hands the decision of whether to continue (or not) the clinical process of transsexuality. (…) This impels transsexual people, being as they are really interested in getting approval for hormone treatment and surgical interventions, to construct adequate biographies to fit the criteria previously defined into the clinical protocols. Sometimes, they hide or camouflage their own stories. (Garaizabal 2006, 166) [Translated by the author.]

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The Guide proposal follows the path marked by Garaizabal, but it has a new approach that goes more deeply, and radicalizes the premise of Garaizabal's proposal (Garaizabal 2003, 2006). I have to point out that the legal framework and the clinical practice are very different from the first proposal—first theorized in 2003—to The Guide proposal published in 2010. The Guide proposal was made after the 'Gender Identity Law' passed in 2007 and in a new clinical context with the progressive creation and spread of Unidad de Trastornos de Identidad de Género (UTIG) (Gender Identity Disorder Unit) within the public healthcare system in Spain.

The main tasks assigned to health professionals in The Guide are basically related to accompanying trans people in the process; helping to raise awareness; and to assist in adjusting expectations during the process of change. There is not one single specific task related to diagnosis in The Guide. Furthermore, the explicit exclusion of any reference to psychiatric attention to trans people, as well as the exclusion of any reference to real-life experience is remarkable (Red por la Despatologización de las Identidades Trans del Estado Español 2010b, 22-23). In this sense, The Guide implies a process of complete redefining psychosocial practices related to trans identity. This *de-psychopathologization* process is a rejection of the authority, knowledge, and practices of mental health professionals in the definition of the gender identity of trans people.

Reconfiguration of the demand for intervention

Standards of Care-6 was articulated around a central axis called 'triadic therapy', in line with previous versions of SoC. Triadic therapy basically consists of a process of three steps: first, psychological or psychiatric evaluation and diagnosis, if appropriate, of Gender Identity Disorder (GID) according to the DSM-IV or ICD-10 standards; second, after a letter of recommendation of a mental health professional, a hormone therapy with androgens to transsexuals female to male (FtM), or estrogens, progesterone and testosterone-blocking agents to transsexuals male to female (MtF) (In this step it is possible to undergo minor surgeries and breast surgeries (mastectomy, chest reconstruction, or augmentation mammo-

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plasty)); third, sex reassignment surgery after a second letter of recommendation from a mental health professional (Meyer III et al. 2001).

In the *Best Practices Guide* (2010b) there is a new configuration of the intervention process. The Guide breaks with this model of diagnosis and treatment in three steps, and substitutes it for a new one in which every single trans person is responsible for the process, because they are considered experts on their own processes. This new model needs an exercise of recognition of knowledge—produced by the embodied experience of trans people—on the part of medical professionals. But this model also needs recognition of medical knowledge on the part of trans people implied. This new frame tends to 'democratize' the model of relations between doctors and trans people; at the same time, it implies new actors involved in the process, like social workers and community groups. Moreover, it is very significant that all hormone and surgery technologies are situated at the same level of importance, so there is a democratization inside the medical treatment process (Red por la Despatologización de las Identidades Trans del Estado Español 2010b, 27-29).

Demand of the logic of choice in order to find a better care

In health care, 'patient choice' and 'good care' might sometimes complement each other, but they are usually at odds, as Annemarie Mol explains in *The Logic of Care* (2008). In this work, Mol lays out an opposition between a 'logic of care' inscribed in the exercise of sharing care and interventions, and a 'logic of choice' established in the individualist liberal model, which takes as subject the figure of the independent citizen with consumption capability. But this description of the 'logic of choice' departs from the idea that all patients have a recognized citizen status, and have the possibility of choosing.

However, in the case of trans people's access to citizenship, this citizen status is not guaranteed at all, but also, on many occasions, legislations granted to provide legal recognition of registry changes in name and sex require a diagnosis and a medical transition to reach that recognition. In the case of Spain it implies GID diagnosis and two years of treatment (González-Polledo 2010, 71). In this situation, health professionals can

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both guarantee or exclude trans people from a complete access to citizenship, given that in many cases the non-correspondence between the legal documents and the gender presentation of the person in question limits enormously the possibility of exerting citizenship rights—for those who are granted citizen status—and it favors situations of abuse and discrimination due to transphobia. In this case, the position of citizenship that may grant access to a 'logic of choice' will not be assured, and the demand of autonomy and election becomes the space of possibility from whence to demand a 'logic of care'.

In fact I argue that the articulation of the demand of changes in the diagnostic and care model proposed in The Guide implies an attempt to develop what Mol has called a 'logic of care', settled on the promotion of an exercise of 'co-doctoring' or 'shared doctoring' between medical professionals and trans people (Ortega Arjonilla, Romero Bachiller & Ibáñez Martín 2014). We could identify three implications in this 'shared doctoring':

1. It will mean collaboration between different agents in the medical practice of intervention and care;
2. It will imply a practical exercise—a certain 'tinkering' to adapt to concrete changing situations through flexible strategies that will adapt and compose themselves in relation to the specific requirements of a given situation (Mol, Moser, & Pols 2010);
3. It will involve an exercise of recognition of knowledge, not only on the part of the medical professional, but also in the trans people implied.

Blackboxing of the hormone treatments and surgical interventions

A detailed analysis of The Guide highlights a deep commitment to move over a pathologizing scheme based in a mental health disorder, to a new model based on a process of resituating psychosocial practices related to identity, and recognizing some exclusions produced by these social prac-

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tices. At the same time, analyzing The Guide and the reconfiguration of the demand of intervention regarding SoC-6, I have found that hormone and surgical treatments remain blackboxed—unquestioned. Bruno Latour defines blackboxing in *Pandora's Hope* (1999) as:

> An expression from the sociology of science that refers to the way scientific and technical work is made invisible by its own success. When a machine runs efficiently, when a matter of fact is settled, one need focus only on its inputs and outputs and not on its internal complexity. Thus, paradoxically, the more science and technology succeed, the more opaque and obscure they become. (304)

In the case of the STP Campaign and The Guide, I explain the unquestioning of hormone therapy and surgeries as a blackboxing process of the biomedical technologies in which the important points are the inputs— in the form of dosage of hormones—and outputs—like the size of the breast after mammoplasty surgery, for example. However, The Guide is not questioning the cultural and embodied multiple meanings that hormones and surgeries are producing.

Concluding observations: reframing knowledge through practices

Medicine has been in charge of regulating and normalizing bodies at least since the rise of scientific knowledge. In this biopolitical frame, all deviations from gender norms have been traditionally identified by medicine as mental disorders that have been treated through a psycho-medical intervention. Transsexuality is a fascinating object because of the politics it allows to disclose but also because of the politics it helps to hide.

In this article, I show how some situated practices of a specific transgender collective, the International Campaign STP, are effecting change in the medical treatment of trans bodies, as well as in the medical conceptualization of sexual difference.

Departing from a perspective of an opposite collective (Callon & Rabeharisoa 2003), these health queer activists have been turned into experts, breaking the traditional STS opposition between expert/lay people

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(Epstein 1995). From that expert position, the International Campaign STP proposes a new understanding of trans identity—a non-pathologizing identity—and new ways of medical intervention in trans bodies based on an exercise of democratization and shared doctoring (Mol 2008, 54-56).

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Note

1 Interestingly, as Sandra Fernández explains in detail, transsexuality was introduced in DSM in the 3rd version in 1980, and at the same time, homosexuality was removed from DSM-III (Fernández 2010).

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